MDR Tracking Number: M5-04-1507-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 1-26-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO has determined that the office visits from 1/28/03 through 9/29/03 **were** medically necessary. The office visits with manipulation, aquatic therapy, massage, neuromuscular re-education, therapeutic exercises, mechanical traction, and muscle testing rendered from 1/28/03 through 9/29/03 **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 15, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 99215 for date of service 1/27/03- review of the requester's and respondent's documentation revealed that neither party submitted copies of EOBs, however, review of the reconsideration HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the 1996 Medical Fee Guidelines. The MAR for this code is $103 and the requestor billed $100. **Reimbursement is recommended** in the amount of $100.

CPT code 99080-73 for date of service 1/27/03- review of the requester's and respondent's documentation revealed that neither party submitted copies of EOBs, however, review of the reconsideration HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the 1996 Medical Fee Guidelines. The MAR for this code is $15 and the requestor billed this amount. **Reimbursement is recommended** in the amount of $15.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 1/27/03 through 9/29/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 7th day of October 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

NOTICE OF INDEPENDENT REVIEW DECISION

April 7, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-1507-01
IRO Certificate #: IRO4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained an injury on ___ while pushing an auto scrubber off of a trailer. He reported back pain and spasms. An MRI dated 01/22/03 revealed a disc protrusion at L5-S1 abutting the S1 nerve root. He attended physical therapy and was prescribed anti-inflammatory, muscle relaxant, and analgesic medications.

Requested Service(s)

Office visits, office visits with manipulation, aquatic therapy, massage, neuromuscular re-education, therapeutic exercises, mechanical traction, and muscle testing from 01/28/03 through 09/29/03

Decision

It is determined that the office visits from 01/28/03 through 09/29/03 were medically necessary. The office visits with manipulation, aquatic therapy, massage, neuromuscular re-education, therapeutic exercises, mechanical traction, and muscle testing from 01/28/03 through 09/29/03 were not medically necessary.

Rationale/Basis for Decision

The office visits are medically necessary for treatment in this individual. The patient returned to see the physician due to his back pain, need for medication and for a referral the Texas Rehabilitation Commission. These are all valid reasons for office visits.

The patient reached maximum medical improvement with 0% impairment rating on March 10, 2003; therefore, any treatment after March 10th was not medically necessary. Per a report from Dr. G, dated January 27, 2003, the patient relates the he is doing much better and that the pain has “virtually gone away from his lower back”.

Therefore, the office visits from 01/28/09 through 09/29/03 were medically necessary. However, the office visits with manipulation, aquatic therapy, massage, neuromuscular re-education, therapeutic exercises, mechanical traction, and muscle testing from 01/28/03 through 09/29/03 were not medically necessary.

Sincerely,